DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445422	A. BUILDING _____ B. WING _____	02/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETOWAH HEALTH CARE CENTER	409 GRADY ROAD, PO BOX 967 ETOWAH, TN 37331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During an annual recertification survey and complaint investigation #33229 conducted on February 24, 2014, through February 26, 2014, at Etowah Health Care Center, no deficiencies were cited in relation to the complaint under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide dignity to eight residents of thirty residents observed during the dining observation in the main dining room. The findings included: Observation of the noon dining experience in the main dining room February 24, 2014, at 12:00 p.m., Certified Nurse Aide (CNA) #1 was observed placing clothing protectors on eight residents without asking permission before placing. A visitor was also in the dining room assisting the residents with clothing protectors and did ask each one before putting them on the residents. Interview with the Director of Nursing (DON) on February 24, 2014, at 12:05 p.m., in the dining room, confirmed the CNA was to ask the resident	F 241	F 241 All residents have the potential to be affected. The DON or designee will in-service the nursing staff regarding dignity and respect of resident individuality and the expectation that all residents will be asked their preference of a clothing protector or cloth napkin. The responsible party of those residents identified as unable to indicate their preference will be contacted and their preference will be obtained and care planned. The Nurse Supervisor will observe the dining room daily at each meal to assure that the residents are being asked their preference. Audits will be completed weekly for four weeks or until substantial compliance is achieved as determined by the Quality Assurance Committee.	4/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-14-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 before placing the clothing protector. Interview with the CNA on February 24, 2014, at 12:05 p.m., in the dining room, confirmed the CNA did not ask the residents before placing the clothing protectors on the residents.	F 241	The Quality Assurance Committee members include the Director of Nursing, a Physician, and three other staff members.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a comprehensive care plan for urinary incontinence for one resident (#128) of twenty-two residents reviewed.	F 279	The urinary continence care plan for resident (#128) was reviewed, compared to the last assessment and updated. All residents have the potential to be affected. The DON in-serviced the MDS Coordinators on February twenty sixth regarding changes in a residents urinary incontinence and care plan updating for that change. An audit was completed by the MDS Coordinators on March fourteenth for review of all residents' continence status with comparison to the previous assessment and care plan for accuracy and completeness. The MDS Coordinators will compare the current assessment of urinary continence to the previous one and update the care plan accordingly. The Nurse Supervisor will audit all the care plans from previous week versus the assessment list to assure that the care plans are updated appropriately. Audits will be completed weekly for four weeks or until substantial compliance is achieved as determined by the Quality Assurance Committee.	4/11/14

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F 279	Continued From page 2 The finding included: Resident #128 was admitted on November 14, 2013, with diagnoses of Sepsis, Status Post Cerebrovascular Accident, Aphasia, Rehabilitation, Anemia, Muscle Weakness, and Right Side Hemiplegia. Medical record review of the Quarterly Minimum Data Set (MDS) dated February 6, 2014, revealed the resident had a change in urinary continence from totally continent on admission, to occasionally incontinent (seven or less episodes of incontinence) ninety days later. Further review revealed no comprehensive care plan for urinary incontinence was in the resident's chart. Interview with MDS Coordinator #1, on February 25, 2014, at 3:20 p.m., at the C/D hall nurse's station, confirmed the February 6, 2014 Quarterly MDS assessment for urinary incontinence was correct, as the resident had one episode of incontinence during the 7 day look-back, and confirmed a Care Plan had not been developed for urinary incontinence.	F 279		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 319		

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F 319	Continued From page 3 and interview, the facility failed to follow a psychiatric drug recommendation to increase the antidepressant for one resident (#23) of twenty-two residents reviewed. The findings included: Medical record review revealed resident #23 was admitted to the facility on August 29, 2011, with diagnoses including Senile Psychosis, Dementia, Depressive Disorder, Esophageal Reflux, and Cerebrovascular Disease (stroke). Medical record review of the quarterly Minimum Data Set (MDS) dated December 29, 2013, revealed the resident scored a six on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired, required extensive assistance with the activities of daily living, and had no behavioral symptoms. Medical record review of a nurse's note dated January 7, 2014, at 4:25 p.m., revealed, "...resident slapped another resident for sitting in her place at the table...resident on 15 min (minute) checks and alert charting...residents will remain separated until everyone is calmed..." Medical record review of a Psychiatric Progress Note written by the Psychiatric Nurse Practitioner (NP), dated January 31, 2014, revealed, "...resident is being seen for the management of psychoactive medications used to treat dementia with agitation...resident has had adverse behaviors in the past, usually altercation with other residents...behavior had been fairly stable until recently...has been verbally aggressive with staff and recently hit another resident...is on edge and quick to become anxious and upset...would	F 319		

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F 319	Continued From page 4 like to increase the dosage of Zoloft (antidepressant) and see if the worsening anxiety can be managed with this drug before adjusting the Depakote (medication for mood stabilization) dosage..." Further review revealed "...recommendations...Please notify the Primary Care Physician (PCP) the following...increase Zoloft dosage to 75mg (milligrams) daily for worsening anxiety...continue Depakote for mood stabilization..." Further review revealed the residents PCP signed the "agreement with recommendation" on February 11, 2014. Medical record review of a Physician's Order dated February 21, 2014, revealed, "...(1) discontinue Zoloft 50mg by mouth once daily at bedtime...(2) start Zoloft 75mg by mouth once daily at bedtime (per psychiatric recommendation)..." Medical record review of the Medication Administration Record (MAR) dated February 1, 2014 through February 28, 2014, revealed the resident was received Zoloft 50mg one tablet once daily February 1-20, 2014, and the medication was discontinued on February 20, 2014. Further review of the MAR revealed on February 21, 2014, (10 days after the physician signed the psychiatric recommendations) the Zoloft was changed to 75mg and administered to the resident. Observation on February 24, 2014, at 11:30 a.m., revealed the resident sitting in the dining room eating lunch. Further observation revealed the resident was cooperative and no behaviors were observed. Observation on February 25, 2014, at 9:30 a.m.,	F 319		

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F 319	Continued From page 5 revealed the resident in the hallway in the wheelchair and no behaviors were observed. Interview with the Social Service Director on February 25, 2014, at 3:05 p.m., in the dining room, confirmed the resident was involved in a resident to resident altercation and a psychiatric evaluation was obtained for the resident. Interview with the A and B Hallway Charge Nurse on February 26, 2014, at 8:40 a.m., in the nurse's station, revealed, "...the Psychiatric (NP) seen the resident on January 31, 2014, and made a recommendation to increase the Zoloft to 75mg...the resident's PCP signed the recommendation on February 11, 2014, and the order was not written until February 21, 2014..." Interview with the DON on February 26, 2014, at 9:00 a.m., in the nurse's station, revealed, "...the SSD prints the consults and recommendations and gives them to me for review...I send them to Medical Records and she takes the physician's order to the office for the physician to sign and they bring them back to the facility..." Further interview confirmed the PCP signed the recommendations on February 11, 2014, and the order was not written until February 21, 2014, which was a ten day delay in the resident receiving the increased dosage of the Zoloft..."		F319 The physicians order was received which addressed the psychiatric drug recommendation for resident (#23). A chart audit to review current residents psychiatric consultation recommendations for the past three months was completed March twelfth. No other residents were found to have been affected. New guidelines for psychiatric consultation follow up will be provided to each primary care physician by mail by April eleventh for reference. Medical records will log psychiatric recommendations as they are sent to and returned from the physicians. They will report to the DON and Clinical Nurse Supervisor any recommendations that require follow up with the primary care physician and the Medical Director. The Medical Director will then be notified in the event that recommendations are not returned, for his follow up. The log will be audited weekly by the DON for four weeks or until substantial compliance is achieved as determined by the Quality Assurance Committee.	4/11/14
F 371 SS=D	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 6 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure approriate storage and cleaning of containers and food used for medication administration in one of two medication rooms and one of four medication carts. The findings included: Observation of the A/B hall medication room on February 25, 2014, at 10:30 a.m., revealed a plastic container containing a sixty milliliter syringe, with the plunger and barrel separated, resting on a paper towel, which was on top of a plastic serrated cake slicer. The paper towel appeared to have water marks on it that had dried. Interview with LPN #3 on February 26, 2014, at 10:50 a.m., in the medication room, revealed the syringe was used for refilling plastic, squeezable bottles with applesauce from a bulk container of applesauce. The squeezable containers of applesauce were placed on the medication carts to squeeze applesauce in medication cups to administer medications to residents. Continued interview revealed the squeezable plastic applesauce containers were refilled and dated on third shift and if the applesauce was not used by the "end of the day", the applesauce was discarded. The squeezable bottles were hand washed by the nurses.	F 371		

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F 371	Continued From page 7 Observation of the medication carts on the A/B and C/D halls revealed one of four medication carts had a bottle of applesauce on top of the cart, dated and labeled. Interview with the Director of Nurses (DON) on February 26, 2014, at 1:00 p.m., revealed there was no policy to inform staff on the cleaning of the squeezable palstic applesauce containers. Further interview confirmed the plastic container containing the syringe and cake slicer was not approved for use on the medication carts or medication room.	F 371 F 371 F 371	No residents were identified to be affected. The refillable plastic squeezable bottles were discarded 2/26/14. All residents have the potential to be affected. The DON or designee will in-serviced the licensed nursing staff on March fourteenth for proper food storage and sanitation as related to medication administration. Pre-packaged/ disposable serving containers will be utilized during med pass. Nurse Supervisor will perform audits daily to assure pre-packaged/ disposable serving containers are being used. Audits will be completed weekly for four weeks or until substantial compliance is achieved as determined by the Quality Assurance Committee.	4/11/14